APPENDIX A — OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT DATED AND FILED JUNE 17, 2003

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 02-13913

D. C. Docket No. 01-00129-CV-T-27

MARGENE REID,

Plaintiff-Appellant,

versus

CAPITAL ONE FINANCIAL CORPORATION,
a foreign corporation,

Defendant-Appellee.

Appeal from the United States District Court
for the Middle District of Florida

(June 17, 2003)

Before BARKETT and MARCUS, Circuit Judges, and MILLS*, District Judge.

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* Honorable Richard Mills, United States District Judge for the Central District of Illinois, sitting by designation.

Appendix A

PER CURIAM:

Appellant Margene Reid appeals from the district court's order granting summary judgment in favor of Appellee Capital One Financial Corporation ("Capital One") on her claims brought pursuant to the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001- 1461 ("ERISA"). Reid argues that the district court erred by applying a heightened arbitrary and capricious standard of review to her plan administrator's decision to deny her disability benefits and by determining that the administrator had acted in accordance with the terms of the plan in any event.

We review a district court's grant of summary judgment *de novo*. *See Madray v. Publix Supermarkets, Inc.*, 208 F.3d 1290, 1296 (11th Cir. 2000). In doing so, "we must view all the evidence and all factual inferences reasonably drawn from the evidence in the light most favorable to the nonmoving party." *Stewart v. Happy Herman's Cheshire Bridge, Inc.*, 117 F.3d 1278, 1285 (11th Cir. 1997).

Upon thorough review of the record as well as careful consideration of the parties' briefs and oral arguments, we find no reversible error. The district court correctly ruled that an arbitrary and capricious standard of review is appropriate where, as here, the plan explicitly grants the administrator discretion to determine eligibility for benefits and to construe the terms of the plan. *See Jett v. Blue Cross & Blue Shield of Alabama, Inc.*, 890 F.2d 1137 (11th Cir. 1989). The district court was also correct to apply the "heightened" arbitrary and capricious standard, because Capital One both administers the plan and pays benefits. *See HCA Health Servs.*

of Ga. Inc., v. Employer's Health Ins. Co., 240 F.3d 982, 1001 (11th Cir. 2001). Lastly, we agree with the district court that the administrator correctly denied Reid disability benefits under the terms of the plan, because the plan explicitly requires an independent medical examination to confirm the claimant's disability and an independent medical examination did not confirm Reid's.

Simply put, we affirm based on the well-reasoned and comprehensive opinion of the district court.

AFFIRMED.

APPENDIX B — ORDER OF THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF FLORIDA, TAMPA DIVISION DATED JUNE 13, 2002 AND FILED JUNE 17, 2002

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

Case No. 8:01-CV-129-T-27TGW

MARGENE REID,

Plaintiff(s),

vs.

CAPITAL ONE FINANCIAL CORPORATION, a foreign corporation, and AETNA US HEALTHCARE, a foreign corporation,

Defendant(s).

ORDER

THIS CAUSE came on to be considered on Defendant Capital One's Motion for Summary Judgment (Dkt. 17), Plaintiff's Amended Response to Defendant's Motion for Summary Judgment (Dkt. 31) and Plaintiff's Motion for Summary Judgment (Dkt. 40). The Court having reviewed said pleadings, the record and applicable case authority, having heard oral argument on April 23, 2002 and being otherwise fully advised in the premises, concludes that

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Defendant Capital One's Motion for Summary Judgment should be granted, there being no disputed issues of material fact. Likewise, Plaintiff's Motion for Summary Judgment should be denied.

I. Factual Background

Capital One Financial Corporation ("Capital One") provided its employees with an integrated short-term and long-term disability benefits program ("the Plan"). The short-term and long-term disability benefits program is administered in part and insured in part by Aetna Life Insurance Co. ("Aetna")[1]. Short-term disability benefits are "self insured" by Capital One while long-term disability benefits are insured by Aetna. (*See generally* Mikasa Dep., at 12-14, 16, 44; Mikasa Aff., Ex. 4).

The Plan provides that Capital One has the authority to make and enforce plan rules, establish claims procedures, interpret the Plan and decide claims for benefits. (Mikasa Aff., Ex. 1, s. 7.1, s. 2.1 and s. 2.15). Capital One has delegated some of this authority to Aetna. Eligibility for short-term benefits is determined in the first instance by Aetna, subject to a one time appeal to Aetna, followed by an appeal to Capital One. (Mikasa Dep. at 17-19, 44). Eligibility for long-term benefits is determined by Aetna, subject to a single appeal to Aetna without further appeal to Capital One.

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1. The parties disagree on whether Aetna US Healthcare or Aetna Life Insurance Company is the Plan Administrator for long-term disability benefits.

(*Id.* at 54). Accordingly, Capital One is self funded for short-term benefits and has provided long-term disability benefits under the Plan by purchasing coverage from Aetna.

The Plan provides that short-term disability benefits last 26 weeks and thereafter, long-term disability benefits apply. (Plaintiff's Ex. 1 at CO0677, CO0681, 809-810, 813). An employee cannot receive long-term benefits without exhausting short-term benefits. An employee becomes eligible for long-term disability benefits on the first day following six months of short-term disability benefits. (Mikasa Dep. at 16, 54).

The standard for "disability" under the Plan during the first 24 months of a disability is generally whether the participant is "not able, solely because of disease or injury, to perform the material duties of your own occupation." (Mikasa Aff., Capital One's Ex. 4 at CO0837). The Plan provides that benefits will not be approved if a "requested Independent medical examination . . . fails to confirm your disability." *Id.* at CO0838. (*See also* Mikasa Dep. at 46).

The Plan also provides that Aetna is required to call the employee's doctors to verify the employee's diagnosis and treatment plan. (Plaintiff s Ex. 1 at CO0678). The employee's treating physician is to certify the employee's disability by working with Aetna's medical representatives and Capital One's Managed Income Protection coordinator. (Plaintiff's Ex. 1 at CO0681).

Margene Reid ("Plaintiff") was a full time employee of Capital One. Shortly after beginning employment with

Capital One, she was injured in two automobile accidents which occurred in January and February 1999. (Capital One's Ex. 9 at CO0229). Plaintiff became disabled and did not work from February 21, 1999 through May 10, 1999 (Reid Dep. at 44). Thereafter, Plaintiff returned to work as a part-time employee and received short-term disability benefits under the Plan for approximately five months. In July 1999, Aetna referred Plaintiff for an Independent Medical Examination ("IME") to Dr. Erick A. Grana. (Mikasa Aff., Defendant's Ex. 9 at CO0286-289). Dr. Grana examined Plaintiff and reported that

> At this stage, over five months following the second motor vehicle accident, I do not think the patient needs any further conservative treatment for these soft tissue injuries. The patient should also be able to return to work, full duty. She has been working five days a week and up to five hours per day. She should be able to increase that to eight hours per day or working full-time, full duty.

Id. at CO0289. Based on this opinion, Aetna determined and informed Plaintiff that her short-term disability benefits would be discontinued effective July 28, 1999, subject to an appeal "in writing to this office." *Id.* at CO0236-237. This letter explained the reasons for the denial pursuant to the terms of the Plan and informed Plaintiff of her right to appellate review. *Id.*

Plaintiff appealed by letter dated September 23, 1999. *Id.* at CO0279. Following her submission of additional

medical evidence, Plaintiff's appeal was denied on March 2, 2000. CO0229-230. Aetna's denial letter noted the terms of the Plan deferring to the opinion of the IME, noting Dr. Grana's opinion and advising that the medical evidence submitted by Plaintiff had been reviewed by an Aetna medical director. *Id.*

After Aetna denied Plaintiff's short-term disability claim, Aetna referred Plaintiff to Capital One for a final appeal pursuant to the Plan, which Plaintiff initiated by letter dated March 21, 2000. *Id.* at CO0228. In response, Capital One's Benefits Manager, Mikasa, wrote Plaintiff that she had the right to submit additional evidence for a period of thirty days after filing her appeal and that her claim would then be decided. *Id.* at CO0277. Plaintiff's counsel provided one additional doctor's note by letter dated April 28, 2000. *Id.* at CO0345.

Following the preparation of a memorandum summarizing the information provided to Capital One, a committee reviewed Plaintiff's file. (Mikasa Dep. at 46-7). The committee noted that Plaintiff had terminated her relationship with one of her doctors, Dr. Tedder, immediately after he had recommended that she return to work. (Mikasa Dep. at 46-47; Reid Dep. at 19-20; and Mikasa Aff. Exhibit 9 at CO0372). By letter dated May 30, 2000, Plaintiff's claim was denied "as there was no medical information provided to contradict the findings of the independent medical examination." (Capital One's Ex. 9 at CO0174).

After February 2, 2000, Plaintiff stopped working due to the injuries she sustained in these accidents. (Capital One's

Ex. 9, Randolph's Memo). As of February 3, 2000, Aetna considered this a separate period of disability for Plaintiff as though she had recovered and returned to work fulltime for some period prior to February 3, 2000. (Reid Dep. at 44).

On April 17, 2000, Aetna issued a denial letter, which by its terms applied only to the period after February 3, 2000. *Id.* The denial letter refers to a second IME conducted by Dr. Grana on March 31, 2000, in which he opined,

> [I]t is my professional opinion that the patient is not completely and permanently disabled as a result of the two motor vehicle accidents suffered in 1999. The patient shall be able to perform job du ies at a minimum at the light/medium work capacity.

(Capital One's Ex. D at last page). The record does not reflect that Plaintiff filed an appeal. Rather, on January 18, 2001, Plaintiff filed her action in this Court.

II. Standard Applicable to Summary Judgment

Summary judgment is proper if following discovery, the pleadings, depositions, answers to interrogatories, affidavits and admissions on file show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law. *Celotex Corp. v. Catrett*, 477 U.S. 317 (1986); FED. R. CIV. P. 56. The Court must view all evidence and all factual inferences reasonably drawn from the evidence in the light most favorable to the nonmoving party. *Adickes v. S.H. Kress & Co.*, 398 U.S. 144 (1970); *Stewart v. Happy Herman's Cheshire Bridge, Inc.*, 117 F.3d

1278, 1285 (11th Cir. 1997). Judgment in favor of a party is proper where there is no legally sufficient evidentiary basis for a reasonable jury to find for the nonmoving party on the issue before the Court. FED. R. CIV. P. 56.

Once a party properly makes a summary judgment motion by demonstrating the absence of a genuine issue of material fact, whether or not accompanied by affidavits, the nonmoving party must go beyond the pleadings through the use of affidavits, depositions, answers to interrogatories and admissions on file, and designate specific facts showing that there is a genuine issue for trial. *Celotex*, 477 U.S. at 324. The evidence must be significantly probative to support the claims. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248-49 (1986).

III. Discussion

1. Defendant's Claim Decision for the First Period of Disability (Period after February 21, 1999)

a. Plan Affords Administrator Discretion in Determining Eligibility Benefits

Where an ERISA plan grants discretionary authority to determine eligibility for benefits or to construe its terms, the administrator's decision denying benefits may be reversed only when the administrator's decision was arbitrary and capricious or an abuse of discretion. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 111 (1989). Under the arbitrary and capricious standard, the function of a reviewing court is to determine whether there was a reasonable basis for the

decision based on the facts known to the administrator at the time the decision was made. *See Buckley v. Metropolitan Life*, 115 F.3d 936 (11th Cir. 1997) (*citing Jett v. Blue Cross & Blue Shield of Alabama, Inc.*, 890 F.2d 1137 (11th Cir. 1989)). An administrator's decision will not be disturbed if reasonable. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 111 (1989); *see also Guy v. Southeastern Iron Workers' Welfare Fund*, 877 F.2d 37, 38-39 (11th Cir. 1989). In applying the arbitrary and capricious standard, the Court's role is "'limited to determining whether [Defendant's] interpretation was made rationally and in good faith — not whether it was right.'" *Guy*, 877 F.2d at 39 (*quoting Anderson v. Ciba-Geigy Corp.*, 759 F.2d 1518, 1522 (11th Cir. 1985)). The Court may look only to the facts known to the administrator at the time of the decision denying coverage. *Jett v. Blue Cross & Blue Shield of Alabama, Inc.*, 890 F.2d 1137 (11th Cir. 1989). Provided there is some reasonable basis for Defendant's decision, it must be upheld as not being arbitrary and capricious, even if there is evidence to support a contrary decision. *See Jett*, 890 F.2d at 1139; *see also Blank v. Bethlehem Steel Corp.*, 926 F.2d 1090, 1093 (11th Cir. 1991).

Here, the Plan expressly provides that Capital One has discretionary authority to interpret and apply the Plan. (CO0624). Specifically, the Plan provides that the Plan Administrator has the power "[t]o interpret the Plan, its interpretation thereof in good faith to be final and conclusive on all persons claiming benefits under the Plan." *Id.* Accordingly, the Plan, in unambiguous terms, grants Defendant discretionary authority to interpret whether Plaintiff was entitled to "short-term disability benefits."

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Payne v. Ryder System, Inc. Long Term Disability Plan, 173 F.R.D. 537, 542-43 (M.D. Fla. 1997). Accordingly, the denial of Plaintiff's short-term disability benefits is reviewed under the arbitrary and capricious standard with deference to its factual determinations absent a conflict of interest. *Levinson v. Reliance Standard Life Insurance Co.*, 245 F.3d 1321, 1326 (11th Cir. 2001).

Heightened Arbitrary and Capricious Standard

In certain cases, a heightened standard of review is appropriate when an insurer is also the claims fiduciary under an ERISA plan and a conflict of interest exists. *Levinson*, supra; *Brown v. Blue Cross and Blue Shield of Alabama, Inc.*, 898 F.2d 1556 (11th Cir. 1990), *cert. denied*, 498 U.S. 1040 (1991). When a conflict of interest exists, the claims administrator's interpretation of the plan is not entitled to deference. *HCA Health Services of Georgia, Inc. v. Employers Health Ins. Co.*, 240 F.3d 982, 994 (11th Cir. 2000). For example, an administrator acts under a conflict of interest if it pays claims out of its own assets. *Id.* at 1001. Here, Defendant admits that it acts as the Administrator of its own policy and pays claimants out of its own assets. (Admission in Open Court, 4/23/02). Accordingly, its claims decision is subject to the heightened arbitrary and capricious standard. *Levinson*, supra.

Notwithstanding the applicability of the heightened arbitrary and capricious standard of review, it is "fundamental that the fiduciary's interpretation first must be 'wrong' from the perspective of *de novo* review before a reviewing court is concerned with the self-interest of the fiduciary." *Id.*

(*quoting Brown*, 898 F.2d at 1566 n.12). A decision is "wrong" if, after reviewing the plan documents and disputed terms *de novo*, the court disagrees with the administrator's plan interpretation. *HCA Health Services*, 240 F.3d at 993 n.23.

Capital One's decision to terminate Plaintiff's short-term disability benefits was pursuant to a provision of the Plan which required that benefits be terminated if an independent medical examination fails to confirm a participant's disability. The Plan provided that benefits would not be approved if a

> Requested independent medical examination . . . fails to confirm your disability. (Mikasa Aff., Ex. 4 at CO0838)

Capital One's decision to terminate Plaintiff's short-term disability benefits was consistent with this provision.

Pursuant to Dr. Grana's July 1999 IME report, information provided by Plaintiff, her physician, AETNA and the plan documents, the Capital One's Benefits Committee reasonably determined that Plaintiff could perform the sedentary duties of her customer relations associate position without any additional time off. (CO0174). Although Plaintiff's physicians' opinions differed from the IME report, Capital One was authorized to resolve any conflicting opinions among the medical professionals when the "decision came down to a permissible choice between the position of [the insurance company's] independent medical consultant and the position of [the claimant's physicians]". *See Donato v. Metropolitan Life Ins. Co.*, 19 F.3d 375, 380 (7th Cir. 1994).

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Although Plaintiff maintains that Defendant failed to comply with the provision in the Plan which required Aetna to call her physicians to verify her diagnosis and treatment plan, (*see* Plaintiff's Ex. 1 at CO0678), that omission does not establish that Defendant's decision was arbitrary, capricious or unreasonable.[2] The Plan unambiguously states that if the requested IME fails to confirm Plaintiff's disability, benefits would not be approved. (*See* Mikasa Aff., Ex. 4 at CO0838). Plaintiff's IME did not confirm any disability. Rather, an independent physician concluded after examining Plaintiff that she should be able to return to work, full duty and that no further conservative treatment was needed for Plaintiff's soft tissue injuries. (Mikasa Aff., Defendant's Ex. 9 at CO0286-289). Given the conclusions of the IME physician, Defendant acted reasonably and in accordance with the terms of the Plan in denying Plaintiff's request for benefits.

Here, Capital One's Administrator had a reasonable basis for the decision, based upon the facts known to her at the time the decision was made, to wit, Dr. Grana's IME report. *See Levinson*, 245 F.3d at 1326; *HCA Health Services*, 240 F.3d at 994; *Jett*, 890 F.2d at 1139; *Paramore v. Delta Air Lines, Inc.*, 129 F.3d 1446, 1451 (11th Cir. 1997). After a *de novo* review of the record, the Court finds Defendant's decision to deny the benefits was not "wrong", and accordingly it is unnecessary to address whether Defendant was acting with the self-interest of a fiduciary. *Payne*, 173 F.R.D. at 542-43.

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2. Plaintiff's treating physician, Dr. McGinn, had relocated at the time of Defendant's decision and was unavailable. Plaintiff's treatment with Dr. Bolin for her TMJ injury began after Defendant made its decision and therefore Dr. Bolin was not available.

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To the extent that Plaintiff now relies on evidence or theories that were not presented to Capital One during the administrative decision making process, Plaintiff is barred from raising those new theories, argument or evidence. An administrator must make a decision "based upon the facts known to the administrator at the time the decision was made". *Jett v. Blue Cross and Blue Shield of Alabama*, 890 F.2d 1137, 1139 (11th Cir. 1987) (under arbitrary and capricious standard); *accord Ravenscraft v. Hy-Vee Employee Benefit Plan and Trust*, 85 F.3d 398, 401-02 (8th Cir. 1996) (refusing to consider new theory even under non-discretionary, *de novo* review).

3. Exhaustion of Administrative Remedies for the Second Period of Disability (Period after February 3, 2000)

Capital One argues that Plaintiff has not exhausted her administrative remedies for her claim to benefits for the period after February 3, 2000. In *Mason v. Continental Group, Inc.*, 763 F.2d 1219 (11th Cir. 1995), *cert denied*, 474 U.S. 1087 (1986), the Eleventh Circuit explained the need for exhaustion in ERISA cases:

> Compelling considerations exist for plaintiffs to exhaust administrative remedies prior to instituting a lawsuit. Administrative claim-resolution procedures reduce the number of frivolous lawsuits under ERISA, minimize the cost of dispute resolution, enhance the plan's trustees' ability to carry out their fiduciary duties expertly and efficiently by preventing premature judicial intervention in the decisionmaking

> process, and allow prior fully considered actions by . . . trustees to assist courts if the dispute is eventually litigated.

763 F.2d at 1227. *See also Springer v. Wal-Mart Associates' Group Health Plan*, 908 F.2d 897, 900 (11th Cir. 1990) ("no longer open to serious dispute that plaintiffs in ordinary breach-of-contract ERISA actions must normally exhaust available administrative remedies.").

Defendant's argument in this regard has merit. Plaintiff stopped working entirely in early February 2000. As Capital One acknowledges, for reasons which are not entirely clear, Aetna considered the time after February 3, 2000, as a separate period of disability for Plaintiff, consistent with treating Plaintiff as though she had recovered and returned to work full time for some period prior to February 3, 2000 (which she had not done, Reid Dep. at p. 44).

Plaintiff's counsel was on notice that Aetna considered the period after February 3, 2000 as a new and separate claim, as evidenced by his correspondence dated April 5, 2000. (Mikasa Dep., Ex. 1, #270). Thereafter, Aetna issued a denial letter on April 17, 2000, which by its terms applied only to the period after February 3, 2000. Despite having received this denial letter for the period after February 3, 2000, Plaintiff did not pursue her appeal as provided in the Plan. Under the Plan, eligibility for short-term benefits is determined in the first instance by Aetna, and then reviewed by a first appeal to Aetna, followed by a second appeal to Capital One. (Mikasa Dep. at 17-19, 44). Accordingly, Plaintiff has not exhausted her available administrative remedies for her claim for benefits after February 3, 2000.

For the foregoing reasons, the Court finds that there are no material issues of disputed fact and Capital One's Motion for Summary Judgment (Dkt. 17) should be and is hereby GRANTED. Plaintiff's Motion for Summary Judgment (Dkt. 40) should be and is hereby DENIED.[3] The Clerk is direct to close this file and terminate any pending motions.

DONE AND ORDERED in chambers this 13th day of June, 2002.

s/ James D. Whittemore
JAMES D. WHITTEMORE
United States District Judge

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3. To the extent that Plaintiff arguably sought long-term disability benefits from Capital One, that claim is properly brought against the appropriate Aetna entity, rather than Capital One.

APPENDIX C — STATUTES AND REGULATIONS INVOLVED

29 U.S.C. § 1001. Congressional findings and declaration of policy

* * *

(b) It is hereby declared to be the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, . . . establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

* * *

29 U.S.C. § 1133. Claims procedure

In accordance with regulations of the Secretary, every employee benefit plan shall—

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

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29 C.F.R. § 2560.503-1 Claims procedure.

(a) Scope and purpose. In accordance with the authority of sections 503 and 505 of the Employee Retirement Income Security Act of 1974 (ERISA or the Act), 29 U.S.C. § 1133, § 1135, this section sets forth minimum requirements for employee benefit plan procedures pertaining to claims for benefits by participants and beneficiaries (hereinafter referred to as claimants). ***

(b) Obligation to establish and maintain reasonable claims procedures. Every employee benefit plan shall establish and maintain reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations (hereinafter collectively referred to as claims procedures). The claims procedures for a plan will be deemed to be reasonable only if—

(1) The claims procedures comply with the requirements of paragraphs (c), (d), (e), (f), (g), (h), (i), and (j) of this section, as appropriate, except to the extent that the claims procedures are deemed to comply with some or all of such provisions pursuant to paragraph (b)(6) of this section;

* * *

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(e) Claim for benefits. For purposes of this section, a claim for benefits is a request for a plan benefit or benefits made by a claimant in accordance with a plan's reasonable procedure for filing benefit claims. ***

(g) Manner and content of notification of benefit determination.

(1) Except as provided in paragraph (g)(2) of this section, the plan administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. ***

(iv). The notification shall set forth, in a manner calculated to be understood by the claimant—

(i) The specific reason or reasons for the adverse determination;

(ii) Reference to the specific plan provisions on which the determination is based;

(iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

* * *

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(h) Appeal of adverse benefit determinations.

(1) In general. Every employee benefit plan shall establish and maintain a procedure by which a claimant shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the plan, and under which there will be a full and fair review of the claim and the adverse benefit determination.

(2) Full and fair review. Except as provided in paragraphs (h)(3) and (h)(4) of this section, the claims procedures of a plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures—

* * *

(ii) Provide claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

* * *

(iv) Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim,

without regard to whether such information was submitted or considered in the initial benefit determination.

* * *

(4) Plans providing disability benefits. The claims procedures of a plan providing disability benefits will not, with respect to claims for such benefits, be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures comply with the requirements of paragraphs (h)(2)(ii) through (iv) and (h)(3)(i) through (v) of this section.

* * * *